SIHO INSURANCE SERVICES

CHANGE REQUEST FORM

Please either mail this form to SIHO, 417 Washington Street, Columbus, IN 47201 attn: Membership, fax it to 812-373-8717 or email to membership.dept@siho.org.

Changes

Employer_____ Group No. _____

Employee _____ ID # _____Phone (_____)_____ Email:_____

Change Deductible Plan: Current_____ to New_____ (Open Enrollment Only)

Change Name: ☐ Employee Name ☐ Dependent's Name _____

Reason: ☐ Marriage ☐ Divorce ☐ Other, describe _____

Change Name to _____

Change Life Insurance Beneficiary: ☐ Life ☐ Dependent Life (Dependent Life Beneficiary is Employee)

Primary - Full Name:_____ Relationship_____ %_____

Secondary - Full Name:_____ Relationship_____ %_____

New Address (if applicable): _____

Add Spouse

Name _____ Date of Birth _____

Please check which coverage(s) to add: ☐ Medical ☐ Dental ☐ Vision

Reason to add _____ Spouse employed: ☐ Yes ☐ No Spouse's S.S. #_____

What is the Qualifying Event: _____Date of Qualifying Event_____

If enrollment is due to a qualifying event, proof of qualifying event (divorce decree, Certificate of Creditable Coverage, Medicaid or other) must accompany this form.

Employer Name/Address_____

Spouse insured elsewhere? ☐ **Yes** ☐ **No** If yes, Insured by _____ Policy #: _____

Add Children

Full Name	Sex M / F	Birthday M/D/Y	S.S. Number	Reason to Add	Date of Qualifying Event

Please check which coverage(s) to add: ☐ Medical ☐ Dental ☐ Vision

Children insured elsewhere? o **Yes** o **No** If yes, Insurance Co.: _____ Policy #: _____

Are any of the other Dependents listed above in the legal custody of another person? ☐ **Yes** ☐ **No** If yes:

If enrollment is due to a qualifying event, proof of qualifying event (divorce decree, Certificate of Creditable Coverage, Medicaid or other) must accompany this form.

Dependent	Person with Legal Custody	Relationship to Dependent	Address of Custodian

Termination

☐ Termination of Employment, indicate last day of work _____ ☐ Voluntary ☐ Involuntary

(Benefits will end on last day of month following termination.)

☐ Employee Request for Termination of Benefits (benefits will end on last day of month):

☐ Delete employee coverage, effective date _____ Reason: _____

Please check which coverage(s) to delete: ☐ Medical ☐ Dental ☐ Vision ☐ Dependent Life ☐ Life

If applicable, is Employee Life only? ☐ Yes ☐ No

☐ Delete spouse's coverage, effective date _____ Reason: _____

Please check which coverage(s) to delete: ☐ Medical ☐ Dental ☐ Vision

☐ Delete children's coverage, effective date _____ Reason: _____

Please check which coverage(s) to delete: ☐ Medical ☐ Dental ☐ Vision

I authorized SIHO to make the above changes to my current benefits.

Note: No employee signature is necessary if employment is terminated. All other changes must be authorized by the employee.

Employee signature: _____ Date: _____ Employer signature: _____

WARNING: any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits and application or files a claim containing false or deceptive statements is guilty of insurance or health care fraud under state and/or federal law.